STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00088358. Complaint IN00088358 - Substantiated, federal/state deficiencies related to the allegations are cited at F-223. Survey dates: April 6 and 7, 2011 Facility number: 000505 Provider number: 155556 AIM number: 100291120 Survey team: DeAnn Mankell, R.N. Census bed type: SNF: 17 SNF/NF: 108 Total: 125 Census payor type: Medicare: 14 Medicaid: 86 Other: 25 Total: 125 Sample: 9 Miller's Merry Manor Tipton was found to be in substantial compliance with 42 CFR part 483 subpart B in regard to the investigation of complaint IN00088358.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.			
F0223	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.			
SS=A	Based on record review and interview, the facility failed to ensure staff to resident abuse did not occur for 1 of 2 investigations of alleged abuse reported in the past 6 months for 1 of 3 residents with allegations of abuse in a sample of 9 (Residents I and J). Findings include: 1. An allegation of abuse, which was reported as occurring on 10/27/10, involving Residents I and J was reviewed on 11/07/11 at 11:45 A.M. Review of the "Fax/Incident Reporting form" dated 10/28/10,	F0223	**F223 483.13(b),(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION** Please accept the following credible allegation of compliance to the deficient practice cited under tag F223, of which ALL residents had the potential to be affected by. It is the policy of Miller's Health Systems that all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Miller's Health Systems has policies and procedures in place that ensures that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and	04/22/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated an incident date of 10/27/10 at approximately 6:30 P.M. involving Resident I and Resident J with CNA #1 as the staff involved. The description of the incident was "It was reported last evening that ... CNA #1 had spoken to Residents I and J in a very uncompassionate manner. It was witnessed and reported by 2 other CNA's that, while assisting residents with dinner on 1//27, CNA #1 was 'rude' in how she spoke with Resident J. She was heard to have made comments such as '(name of Resident J, stop with the fried chicken crap, you are puree for a reason-you are making me insane' and 'Knock your crap off.' Minutes after this exchange, she was heard in the hallway 'yelling' at Resident I to 'knock his crap off' and that he 'was not getting his shower right now-he has to wait until I say it's time.' This information was reported to the nurse and CNA #1 was removed from the building and suspended pending an investigation." The		misappropriation of resident property are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). Immediately after this incident occurred, the employee in question was suspended pending an investigation and the Administrator and Director of Nursing were notified. Neither of the residents involved, (I) or (J), were found to have been negatively affected by this employee's behavior towards them. A report was submitted to ISDH and to the Ombudsman and a facility investigation began immediately. While investigating, it was found that no other residents were affected by this incident. Miller's Merry Manor regrets this incident occurred, but acted appropriately after the allegation was made. CNA # 1 was terminated after findings from the investigation. All staff were re-educated on resident abuse after the occurrence. On Nov. 22nd, 2010, all staff were in-serviced on preventing,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	report indicated there were no injuries and that Social Services had met with both residents and neither had voiced or acted in any manner to indicate they were had any kind of distress. Review of the follow-up "Fax/Incident Reporting form" dated 11/03/10, for the incident dated 10/27/10 at approximately 6:30 P.M. involving Resident I and Resident J indicated CNA #1 had been terminated from employment for allowing herself to become frustrated and using her words and tone of her words toward the residents. The facility was scheduling an all-staff in-service regarding abuse as a follow-up. The investigation of the verbal abuse had hand written statements from the CNA's who reported the incident. CNA #2 wrote, "Sitting in the		recognizing, and reporting resident abuse. Facility will continue to conduct resident abuse re-education on an ongoing basis at least semi-annually. The social service staff or designee will speak with a total of 6 residents and/or family members weekly for four weeks and then monthly thereafter using the Abuse and Neglect Review Quality Assurance Tool (Attachment # 1A).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dining room, an employee (CNA #1) was talking to a resident (Resident J) in an offensive way! telling her to 'knock her crap off !!!" Also, in the Orchard hallway the same employee was yelling at a different resident to "knock his crap off.' also and that he 'had to wait' until she said 'it was time.' On both occasions family of residents were there and could hear her yelling." CNA #3 wrote, "I overheard (CNA #1) being rude to (Resident J) during supper. She was making comments such as '(Resident J) stop it with the fried chicken crap (sic) you are puree for a reason (sic) you are driving me insane.' Then later that night she was being rude to (Resident I), saying you will listen to me (sic) you are not getting your shower right now. She was yelling the whole time. (Name of a different resident's) son was present the whole time." During an interview on 4/7/11 at 3:55 P.M., with the DON (Director			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of Nurses) she indicated CNA #2 had told her nurse of the incident right after it had happened and CNA #2 had also, called her at her home. The DON had told the nurse to send CNA #1 home and had called the unit manager to come in and take the place of CNA #1 on the floor. She had notified the Administrator of the allegation of abuse also. She further said the verbal remarks toward Resident I had occurred as CNA #1 was escorting residents from the dining room to their rooms after dinner. She indicated CNA #1 was terminated for abuse. This federal tag relates to complaint IN00088358. 3.1-27(b)			